Navigating Through Pain Management and Prescription Drug Issues

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OPIOIDS – "A GIFT OR A CURSE"?

PHYSIATRIST'S APPROACH TO OPIOID MANAGEMENT

Jeffrey E. Hazlewood, M.D.

June 20, 2013

INTRODUCTION

- Use of opioids in cancer pain is very clear cut
- Use of opioids in non-malignant pain is not
- Even more controversy in treatment of chronic W/C patients (e.g. chronic strains)
- GOAL: Assimilate all the data (which is constantly changing) and be:
  - Fair
  - Consistent
  - Objective
  - Unbiased
  - Cost Effective

INTRODUCTION

- **Being a "W/C Pain Dr." is difficult:**
  - **Difficult role being a treating physician especially when physicians' and societies' opinions on these issues are "across the board"**
  - **AND, the laws and mandates are constantly evolving and changing**

OPIOIDS

- **A lot about opioids is not proven, but *what we <u>do</u> know*:**
  - **Volume of prescribed opioids has increased 600% from 1997 to 2007**
  - **During same period, # of unintentional lethal overdoses has increased >350% (4000 to 14,000)**
  - **Risk of overdose/death increases with higher dosages, especially if taking benzodiazepines**
  - **High dosages do not reliably decrease pts' report of the magnitude of chronic pain, nor do they improve overall health and function**

What is the chance of addiction if an average patient is taking a chronic opioid?

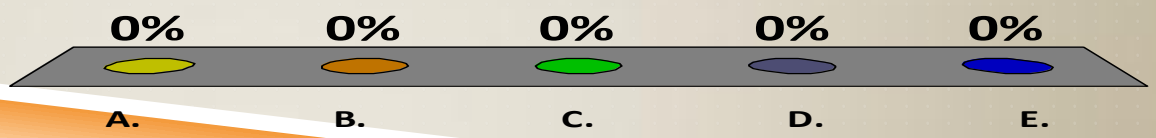
A. approx. 75%

B. approx. 50%

C. approx. 5%

D. approx. 90%

E. approx. 100%



OPIOIDS

- **Opioid Usage:**
  - **On >100 mg MEQ per day**
    - Adverse effects risk increases 9X
    - 80% of overdose deaths (20% are on <100 MEQ/day)
  - **On >200 mg MEQ per day**
    - Mortality rates increase 5X
  - **Meta-analysis of 67 studies: overall *addiction* rate is only 3.27%**
  - ***Tolerance* rate can be up to 50%!!**
    - This occurrence is my biggest problem in the "clinic"

OPIOIDS

- **The "swinging pendulum"**
- **Recommended by the WHO as a part of the analgesic ladder for cancer pain**
- **For chronic non-cancer pain: RCT's indicate high quality evidence for a weak recommendation for opioids when used short term**
- **HOWEVER, *recent studies fail to demonstrate the improvements in many "essential" outcomes including pain, function, and quality of life in patients on these for months or years***

OPIOIDS

- Furthermore, as the number of prescriptions for strong opioids increases, so does the risk of serious adverse effects including inadvertent overdose and death

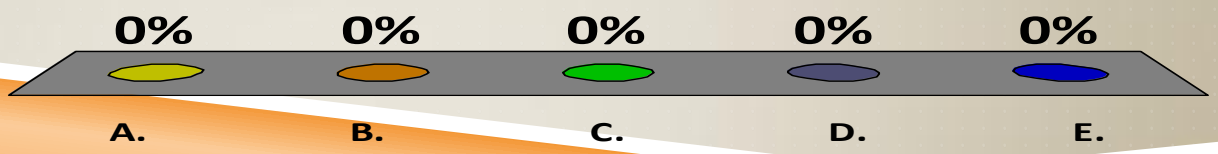
- THEREFORE: patient selection and outcome assessment is essential and long term use should be preceded by a trial in which the goals of treatment are agreed with the patient

OPIOIDS

- **LA opioids *vs* SA opioids:**
  - **A regular LA drug had been recommended over repeated SA drugs:**
    - Better pain control
    - Positive psychological advantages
    - May reduce adverse side effects
    - Maybe with lower risk for addiction/tolerance
  - **However, there is little evidence to support LA opioid usage**
  - **AND, there is a negative "persona" with LA opioids and they are not as cost effective**

What opioid is felt by many to be the most abused drug?

A. Oxycontin
B. Methadone
C. Morphine
D. Codeine
E. ✓ Hydrocodone



OPIOIDS

- **Lortab / Vicodin / Norco / "Hydros"**
  - **Why is there such a love for this drug?**
    - Most addictive and abused opioid out there?
    - It can reduce anxiety, boredom, emotional pain, and increase self esteem
    - There is an "on and off" reward system that can backfire
    - This effect is why a patient may not want to stop the drug even though they report their pain level is 8/10!!

OPIOIDS

- Adverse Effects:
  - Drowsiness
  - GI: constipation, nausea, vomiting
  - Itching
  - Sweating
  - Mood change
  - Respiratory depression
  - Endocrine suppression (esp >100mg MED)
  - Hyperalgesia
  - Dry mouth, tooth decay
  - Addiction, physical dependency, tolerance, death

OPIOIDS

- **Contraindications (?):**
  - **Psychological Issues**
    - Underlying psych distress maybe associated with an increased level of pain perception, bodily awareness and physical symptoms:
      - Chronic fatigue
      - Difficulty concentrating
      - Irritability
      - Muscle tension
      - Appropriate to treat **emotional pain** with narcotics??
      - These patients don't usually respond well

OPIOIDS

- **Contraindications (?):**
  - **History of Drug/Alcohol Abuse**
    - Does not prohibit the use of opioids but may have a substantial risk of overdose
    - Monitor carefully
    - Use only LA opioids if possible
    - Especially avoid oxycodone

What % decrease in pain is the goal of pain management?

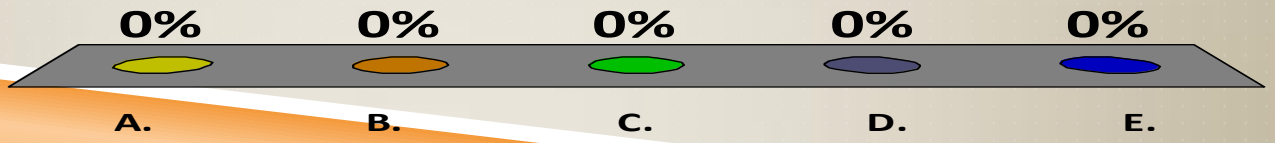
A. 100%

B. 20%

C. 30%

D. 70%

E. 50%



OPIOIDS

- Goal of Pain Intensity Decrease:
  - 30% decrease in pain scores
  - “4/10” on VAS
- Is it worth 30% decrease in pain given the risks in the cases of high dose treatment?
- Cochran Report: poor evidence that opioids are better than placebo in relieving pain and improving function in long term usage

OPIOIDS

- **One review article:**
  - ***"Should use opioids with great restraint and caution and in carefully selected patients"*** **(ASIPP)**
  - **"The failure to set dose limits is irresponsible and hazardous to patients and society"**

OPIOIDS

- **A couple of great quotes to keep in mind:**
  - ***"Opioids are powerful, precious, and dangerous medications and must be used with care and diligence"***
  - ***"As clinicians and as patients, we need to develop a generous measure of respect for the power of opioids to do harm as well as provide relief from pain"***

OPIOIDS

- **Hazlewood's Keys in Chronic Pain Management:**
  - ***"Hold back the reins"!!!***
  - ***"Don't let the horse get out of the barn"!!!***
  - ***"Treat for the marathon, not the sprint"!!!***
  - ***"Rotate, not Escalate"!!!***

APPROPRIATE OPIOID MANAGEMENT

- Good History and Physical Examination
- Record Review
- Determination of Causation
- Appropriateness of Opioids for Diagnosis (Based on Objective Pathology)
- Documentation of Previous Failed Treatments

APPROPRIATE OPIOID MANAGEMENT

- Assess Previous Exhaustion of Other Options
- Assess Risk of Addiction / Compliancy
- Assess Appropriateness of Short-Acting vs Long-Acting Opioid
- Education of Risks of Addiction, Tolerance, Physical Dependency
- Opioid Agreements including Expectations, Risk and Benefits of Opioid Usage
- Close Dr. Supervision of NP's/PA's

APPROPRIATE OPIOID MANAGEMENT

- Utilize Drug Monitoring Methods
  - Narcotic Agreements
  - UDS's (including truly random one)
  - Pill Counts
  - Pharmacy Communication
  - Careful Review of Records
  - Opioid Risk Assessments
  - Appropriate Documentation
  - Discussions with Families
  - Use of State Monitoring Data Bases
  - Appropriate Office Set-up
  - "GUT FEEL" !!!

OPIOIDS – NEW ISSUES

- Extended-release Hydrocodone
  - "Gift or Curse"?
  - No Tylenol
  - Some forms BID and not tamper-resistant, other q day dosing
  - All will be Class II drugs
  - The dosing expected up to 50mg/day (100 mg MEQ)
  - FDA currently assessing whether to schedule SA hydrocodone now as shed II
  - As of next year, no 500 mg formulations will be allowed

OPIOIDS – NEW ISSUES

- **Extended-release Hydrocodone**
  - **Positives:**
    - Hydrocodone is a good pain reliever in many patients
    - Provides an additional option for pain relief in non-responders to other types of opioids, or who cannot tolerate other types
    - Another option for “rotation” in tolerance
    - Less frequent dosing is an advantage

OPIOIDS – NEW ISSUES

- **Extended-release Hydrocodone**
  - **Negatives:**
    - Hydrocodone may be inherently extremely addictive
    - Off-label usage with 2 tabs at a time or q 8 hr dosing – yields 200 mg MED
    - Another “new drug for the street”

OPIOIDS – NEW ISSUES

- **Pharmacogenetics in UDS's:**
  - **Genetic variations can result in clinically significant differences in medication efficacy and toxicity**
  - **Identifying genetic variations may allow clinician to more effectively personalize each patient's treatment**
  - **Can better predict and understand patient's responses to medications; prevent adverse effects**
  - **May explain some false-negative UDS's**

MY OPINION (FOR WHAT IT'S WORTH!)

- **Opioids probably do have a place in management of chronic non-malignant pain <u>but</u> *one must carefully select the patients* and:**
  - **Need regular monitoring**
  - **Need to be part of a multimodal therapy program**
  - **Should not be denied but carefully considered on a case by case basis**
  - **Must have consistency in philosophy of treatment**

MY OPINION

- **BUT:**
  - **I must state that I'm getting more and more conservative in my old age …**
    - Are these patients really better off with these drugs??
    - Is their function truly better??
    - Are the risks really outweighed by the benefits??
    - What about the costs to the system??
    - ***Are these patients really happy people???????????***

QUESTIONS??

Thank-you!!

CONTROLLED SUBSTANCE USE, MONITORING, AND ABUSE IN TENNESSEE

Jason Carter, PharmD

Chief Pharmacist, TN Dept. of Mental Health and Substance Abuse Services

State Opioid Treatment Authority

Associate Professor, University of Tennessee College of Pharmacy

OBJECTIVES

- Review current trends and issues surrounding prescription drug abuse
- Summarize changes passed in the Tennessee Prescription Safety Act of 2012
- Identify current and future issues regarding the Controlled Substance Monitoring Database
- Discuss current state initiatives aimed at reducing prescription drug abuse in Tennessee

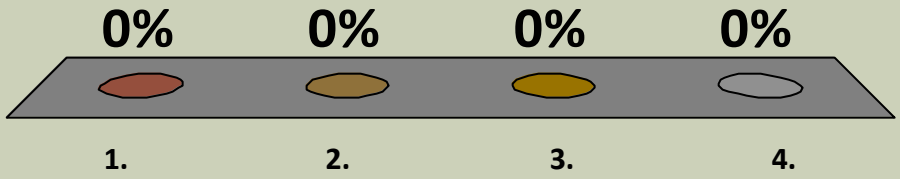
BACKGROUND AND STATISTICS: TENNESSEE

PRESCRIPTION DRUGS EPIDEMIC IN TENNESSEE

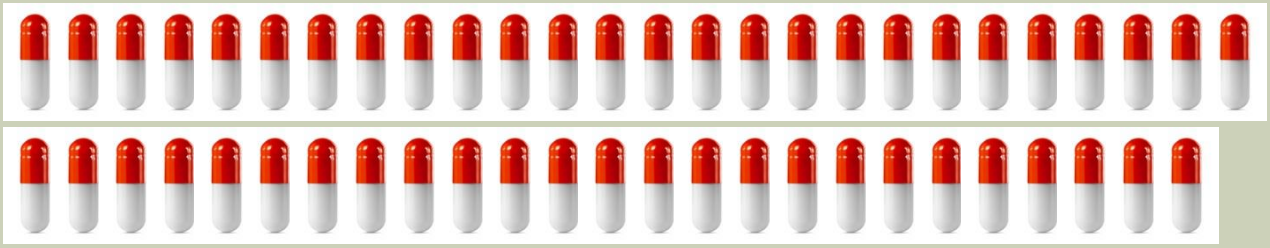
- 2nd leading state in US in pounds of opiate pain relievers drugs sold.
- Prescription opioids ranked #1 abused drug among individuals receiving state-funded treatment services
- From 2010 to 2011 – a 15% increase in convicted DUI offenders abusing opiates
- Cost of caring for children in state custody increased from $29 million in 2008 to $52 million in 2011

HOW MANY HYDROCODONE WERE DISPENSED IN TENNESSEE LAST YEAR?

1. 25,000,000
2. 50,000,000
3. 100,000,000
4. ✓ 200,000,000



PILLS PER TENNESSEAN



275.5 Million Hydrocodone Pills

51 pills
per every
Tennessean
over age 12

116.6 Million Xanax Pills

22 pills
per every
Tennessean
over age 12

113.5 Million Oxycodone Pills

21 pills
per every
Tennessean
over age 12

PRESCRIPTION DRUGS EPIDEMIC IN TENNESSEE

- Deaths rose from 422 in 2001 to 1,063 in 2011. The vast majority were unintentional.
- In 2010, there were more deaths due to drug overdose than from motor vehicle crashes, homicide or suicide.
- 40% of deaths were in the 25-44 age group.
- Both an urban and rural problem – more heavily involved in Upper East and East Tennessee but is moving to the west.

IN WHAT TYPE OF AREA ARE CONTROLLED SUBSTANCES MOST OFTEN DISPENSED?

1. Metropolitan
2. Rural

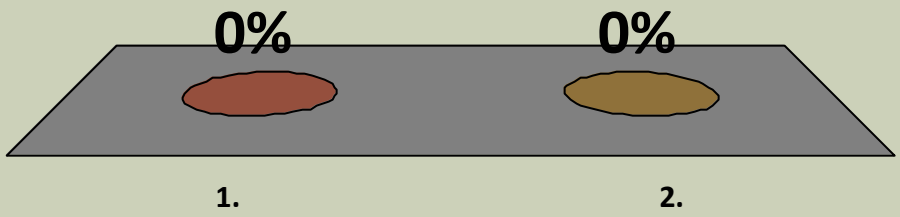
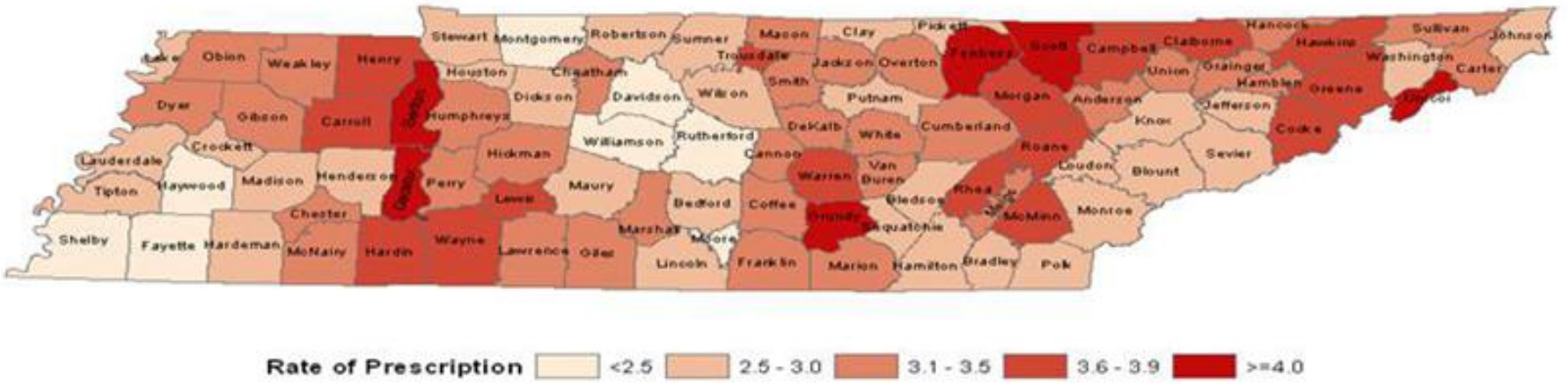


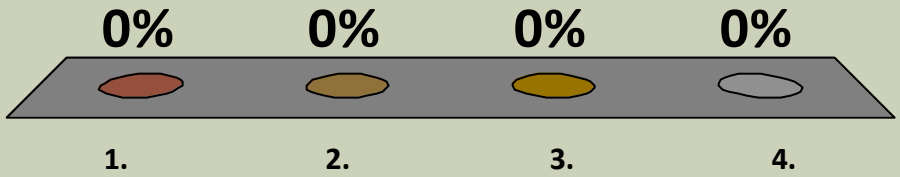
Figure 8. Number of Prescriptions Dispensed in Tennessee Among Tennessee Residents Reported to CSMD, 2012

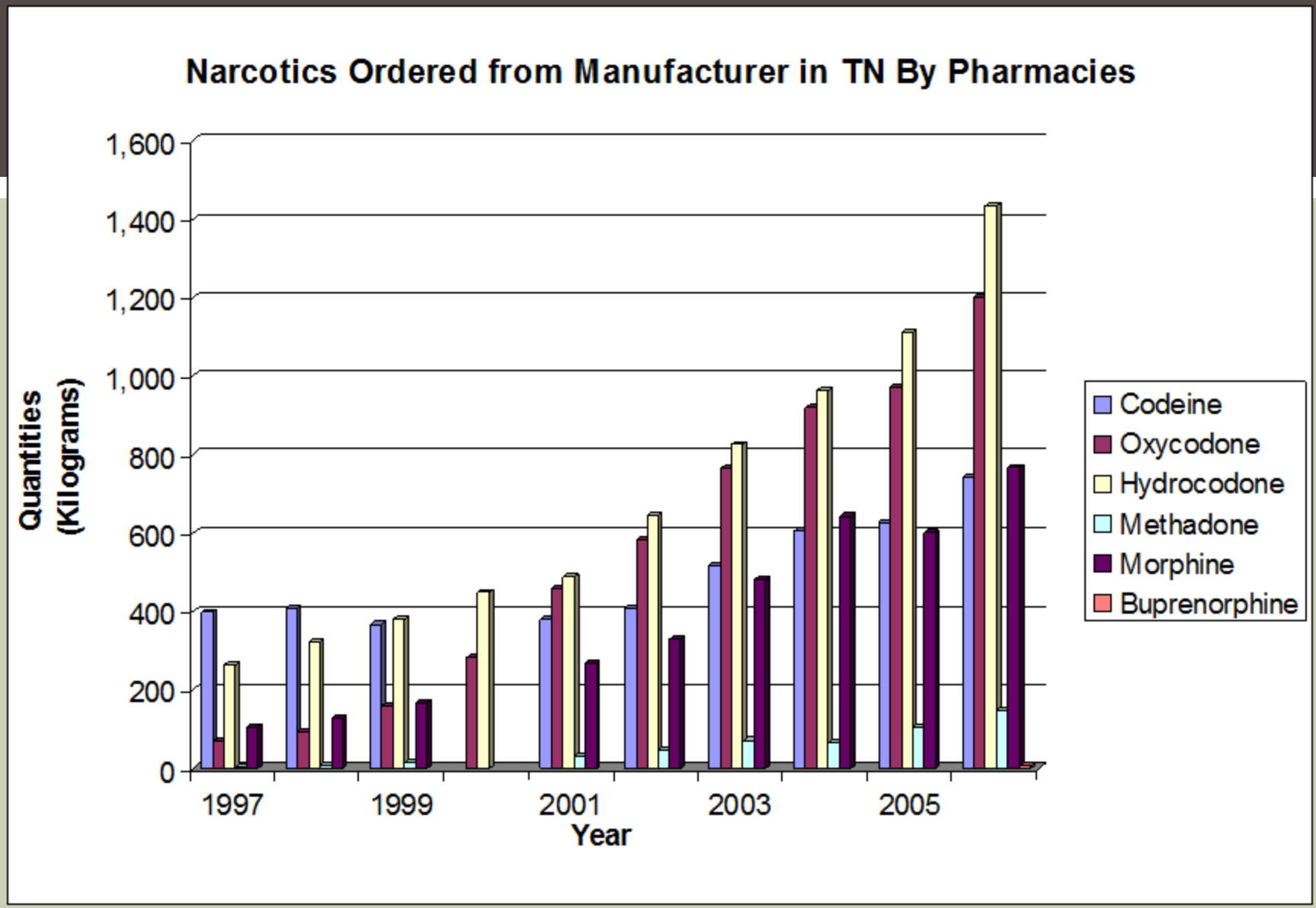
Figure 9. Rate of Prescriptions Dispensed (per capita) in Tennessee Among Tennessee Residents Reported to CSMD, 2012



WHAT IS THE MOST COMMONLY PRESCRIBED CONTROLLED SUBSTANCE IN TENNESSEE?

1. Xanax (alprazolam)
2. Vicodin/Lortab (hydrocodone)
3. Oxycontin/Percocet (Oxycodone)
4. Ambien (zolpidem)





Source: ARCOS, Department Of Justice, Drug Enforcement Administration

**Data inexplicably unavailable from source (2000)

TOP PRESCRIBED CONTROLLED SUBSTANCES IN TENNESSEE

2010	2012
1. Hydrocodone/APAP	1. Hydrocodone/APAP
2. Alprazolam	2. Alprazolam
3. Oxycodone	3. Oxycodone/APAP
4. Codeine	4. Oxycodone
5. Clonazepam	5. Tramadol
6. Zolpidem	6. Zolpidem
7. Lorazepam	7. Clonazepam
8. Diazepam	8. Lorazepam
9. Propoxyphene	9. Pregabalin
10. Pregabalin	10. Carisoprodol

Data from TN CSMD Advisory Committee. April 2012

BACKGROUND AND STATISTICS: UNITED STATES

BACKGROUND AND STATISTICS

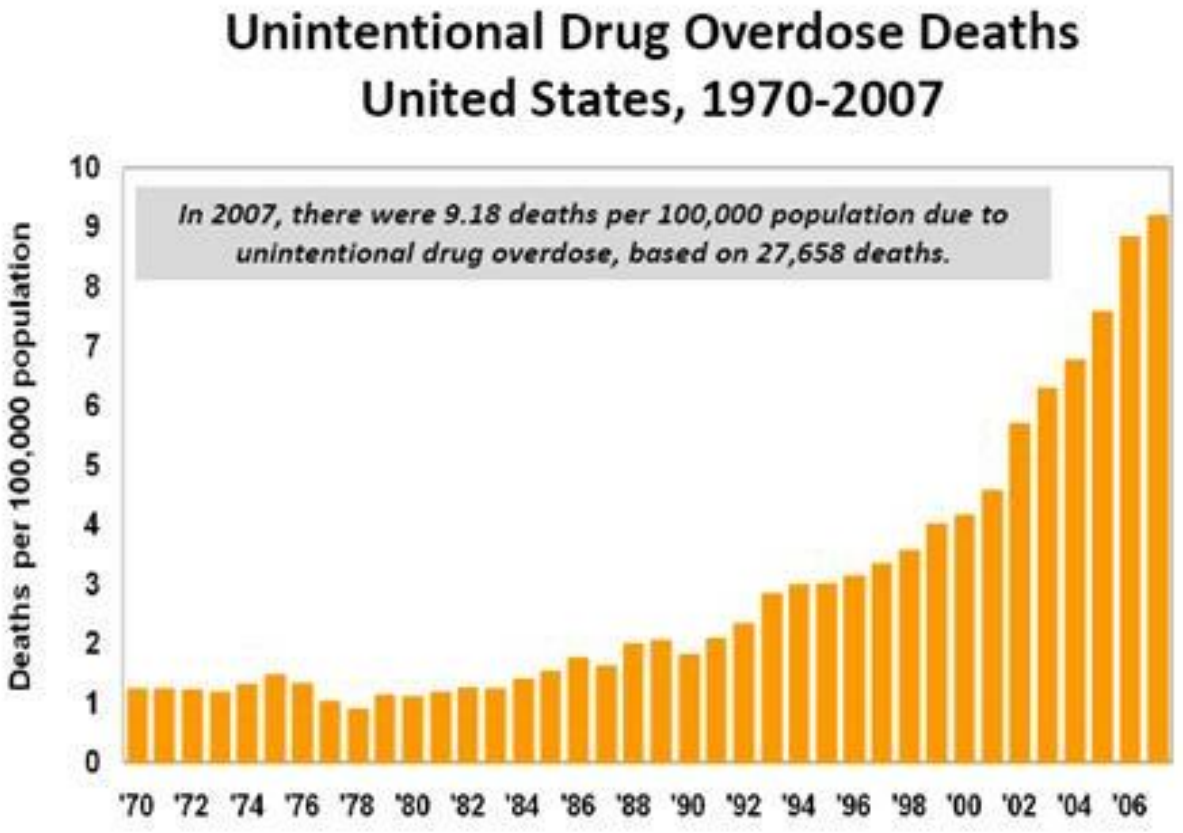
- Prescription drug abuse is the *intentional* use of a medication:
  - without a prescription;
  - in a way other than as prescribed; OR
  - for the experience or feeling it causes.
- Approximately 7.0 million persons were current users of psychotherapeutic drugs taken non-medically in the US in 2010 (2.7% of US population)
  - Pain relievers - 5.1 million
  - Tranquilizers - 2.2 million
  - Stimulants - 1.1 million
  - Sedatives - 0.4 million

BACKGROUND AND STATISTICS

- Prescription painkiller overdoses killed nearly 15,000 people in the US in 2008. This is more than 3 times the 4,000 people killed by these drugs in 1999.
- In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.
- Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers.
- It is estimated that 20 percent of people in the United States have used prescription drugs for nonmedical reasons
- Nonmedical use of prescription painkillers costs health insurers up to $72.5 billion annually in direct health care costs.

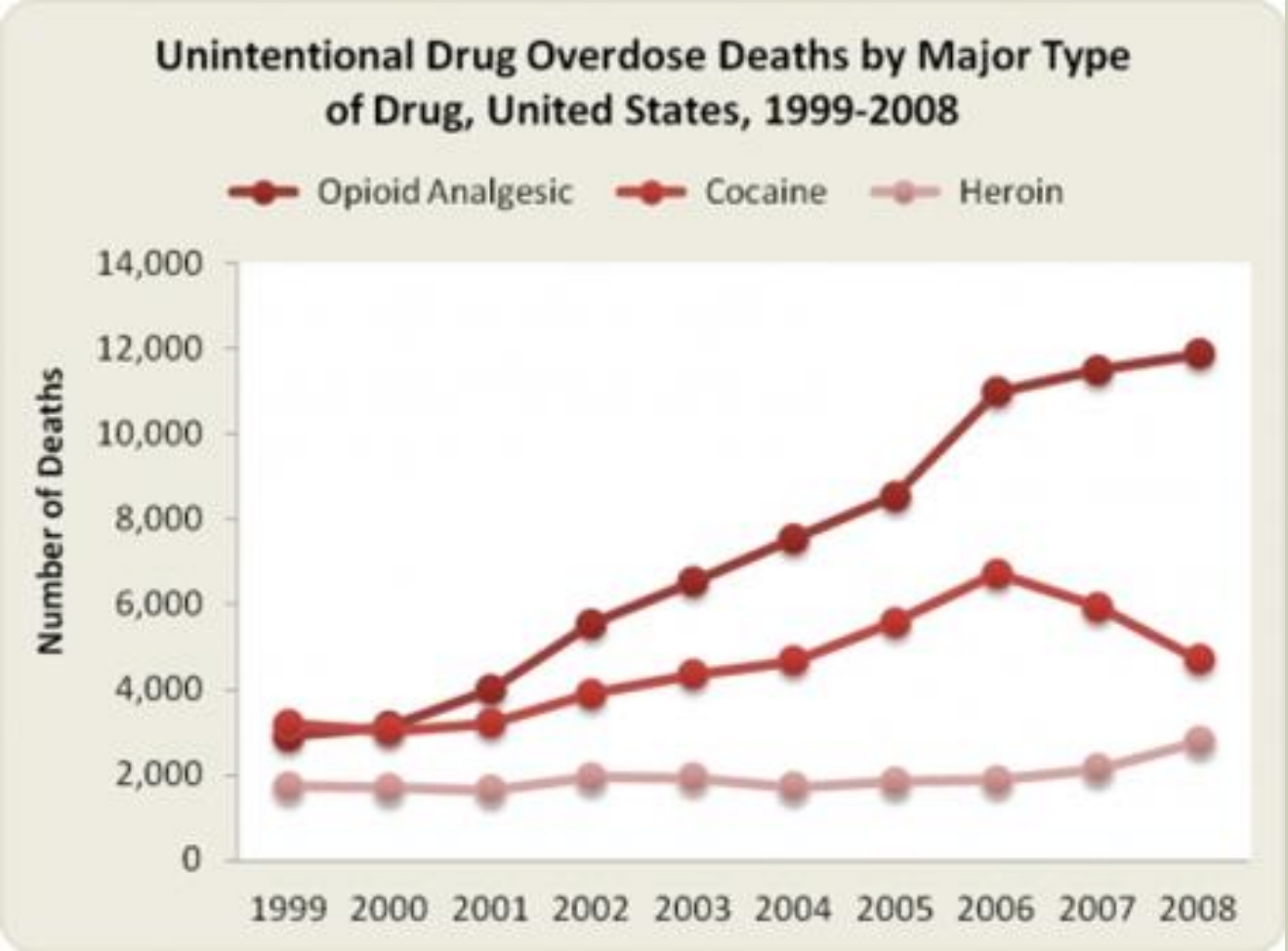
ABUSE TRENDS

OVERDOSE DEATHS



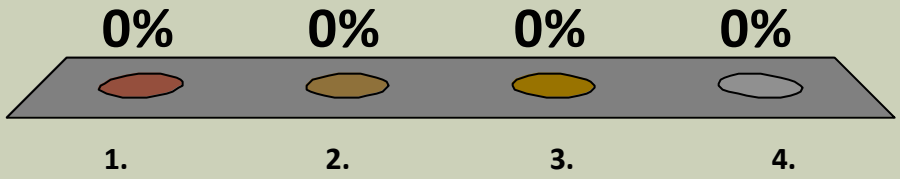
Source: Centers for Disease Control and Prevention. *Unintentional Drug Poisoning in the United States* (July 2010).

ABUSE TRENDS



WHERE DO PEOPLE THAT ABUSE PRESCRIPTION DRUGS GET THEM?

1. Drug dealer
2. ✓ Free from friend or family
3. Stolen from friend or family
4. One doctor



ABUSE TRENDS

People who abuse prescription painkillers get drugs from a variety of sources[7]

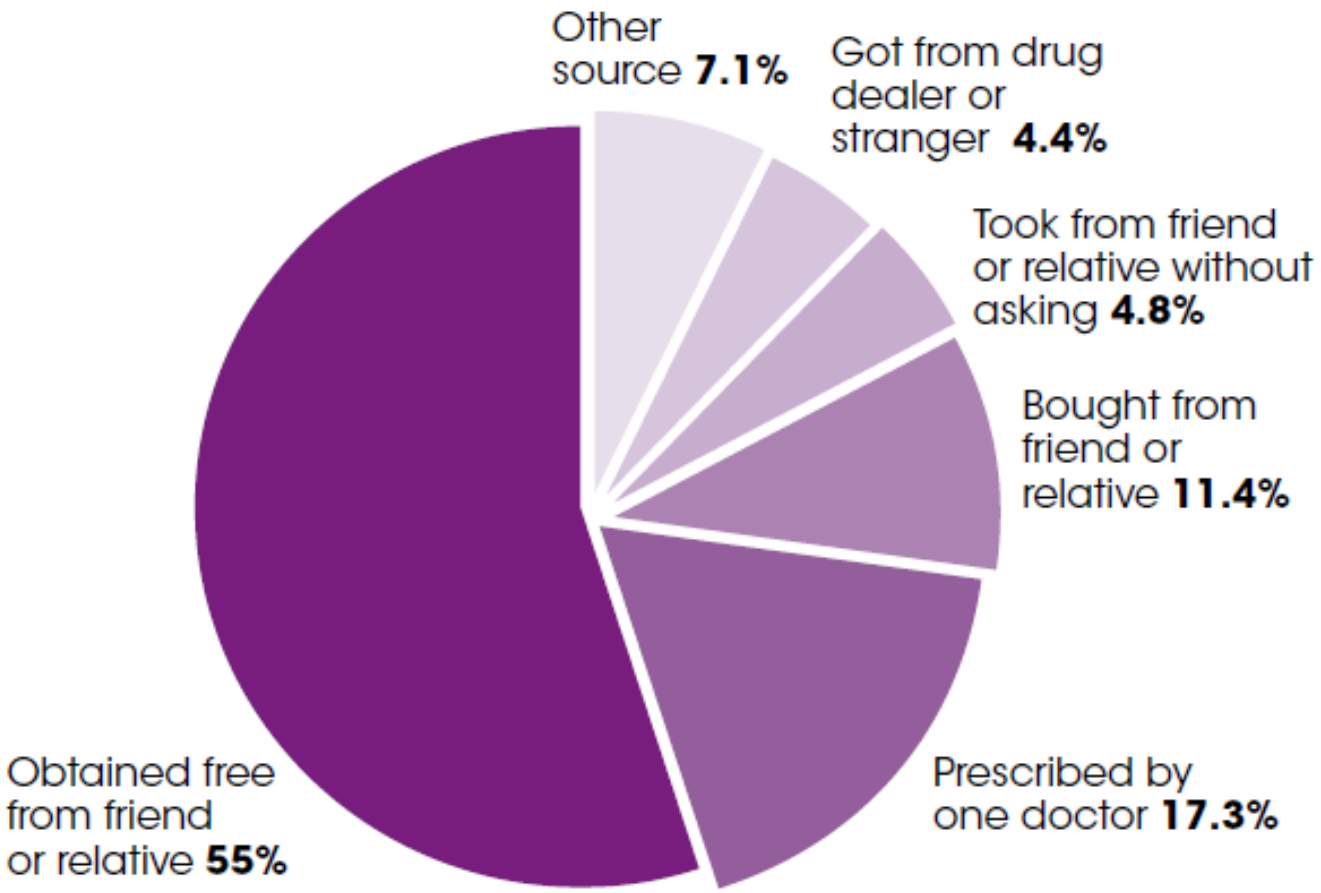


Table 4. Select Misused or Abused Drugs with Increasing Involvement in Emergency Department (ED) Visits: 2004 to 2009

Drugs	Number of ED Visits In 2009	Percent Increase In Number of ED Visits, 2004 to 2009
Drugs to Treat Insomnia or Anxiety: Zolpidem	35,438	154.9
Drugs to Treat Insomnia or Anxiety: Alprazolam	140,657	148.3
Drugs to Treat Insomnia or Anxiety: Clonazepam	69,620	114.8
Drugs to Treat Insomnia or Anxiety: Lorazepam	42,602	104.3
Illicit Drugs: Ecstasy (MDMA)	22,816	123.2
Narcotic Pain Relievers: Oxycodone Products	175,949	242.2
Narcotic Pain Relievers: Morphine Products	34,282	133.3
Narcotic Pain Relievers: Hydrocodone Products	104,490	124.5
Narcotic Pain Relievers: Fentanyl Products	22,143	117.5
Metabolic Agents: Antidiabetic Agents	28,088	223.6
Muscle Relaxants: Carisoprodol	31,763	100.6

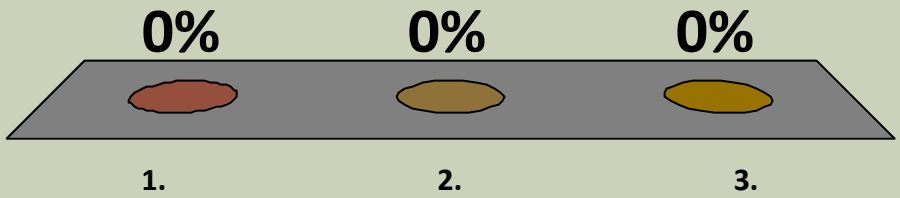
Source: 2004 to 2009 SAMHSA Drug Abuse Warning Network (DAWN).

ASSESSING THE HISTORY OF OPIOID ABUSE IN PATIENTS RECEIVING TREATMENT IN TENNESSEE OPIOID TREATMENT PROGRAMS

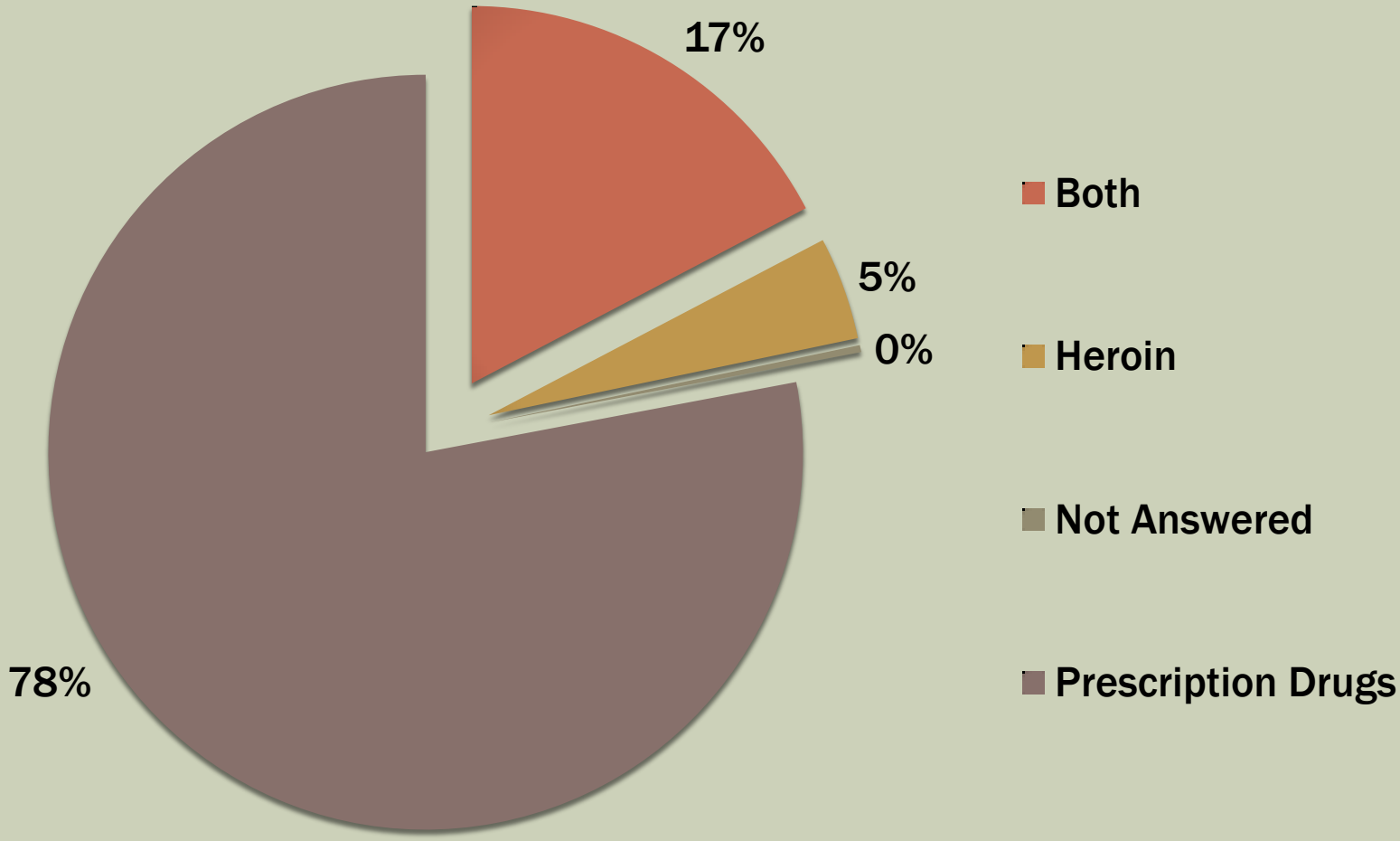
Jason Carter, Wesley Geminn, Todd Bess, Joseph Pandit
University of Tennessee College of Pharmacy
Tennessee Department of Mental Health
Nashville, TN

WHY ARE MOST PATIENTS RECEIVING TREATMENT AT OPIOID TREATMENT PROGRAMS IN TENNESSEE?

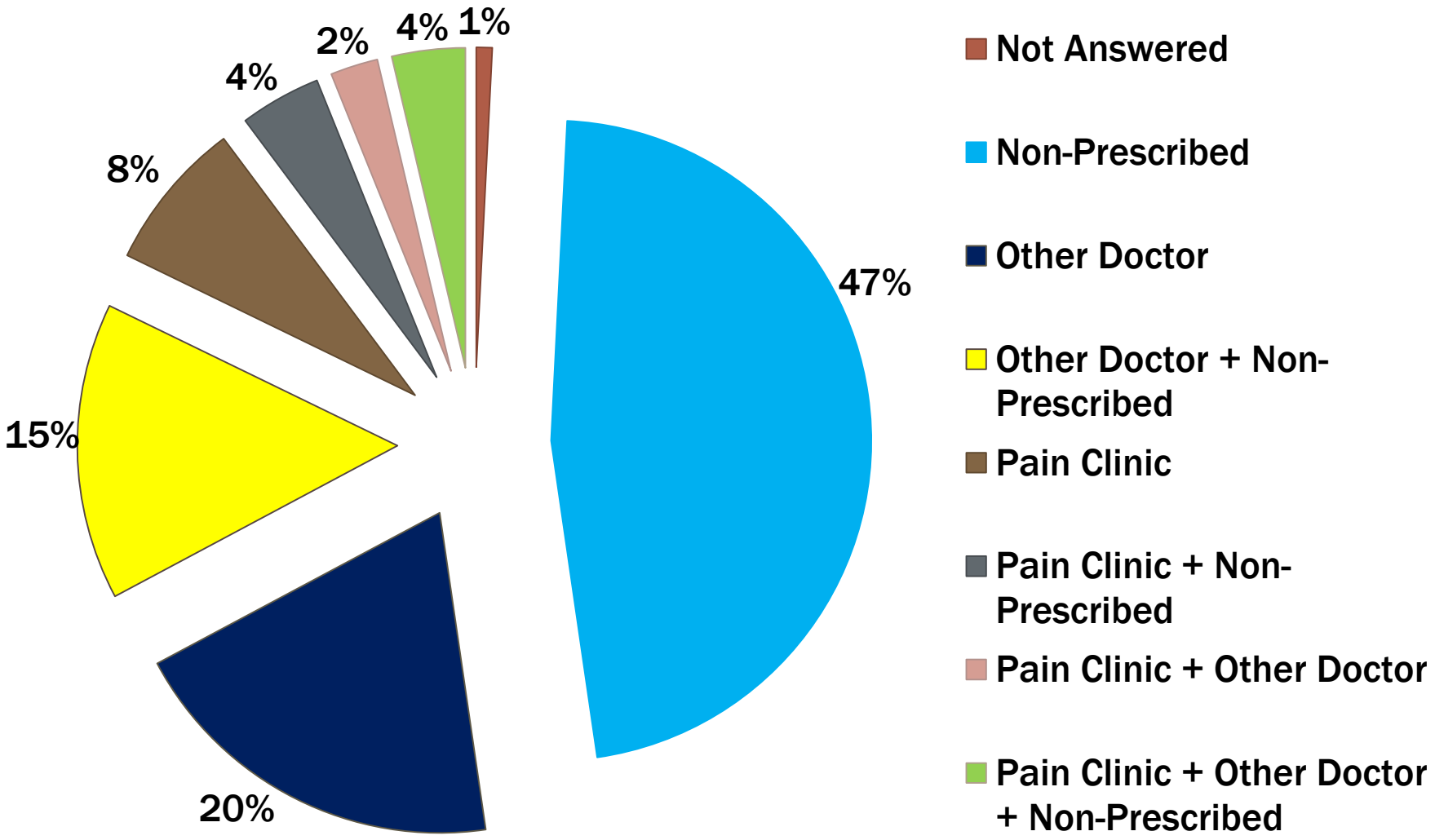
1. Heroin addiction
2. Prescription drugs
3. Both



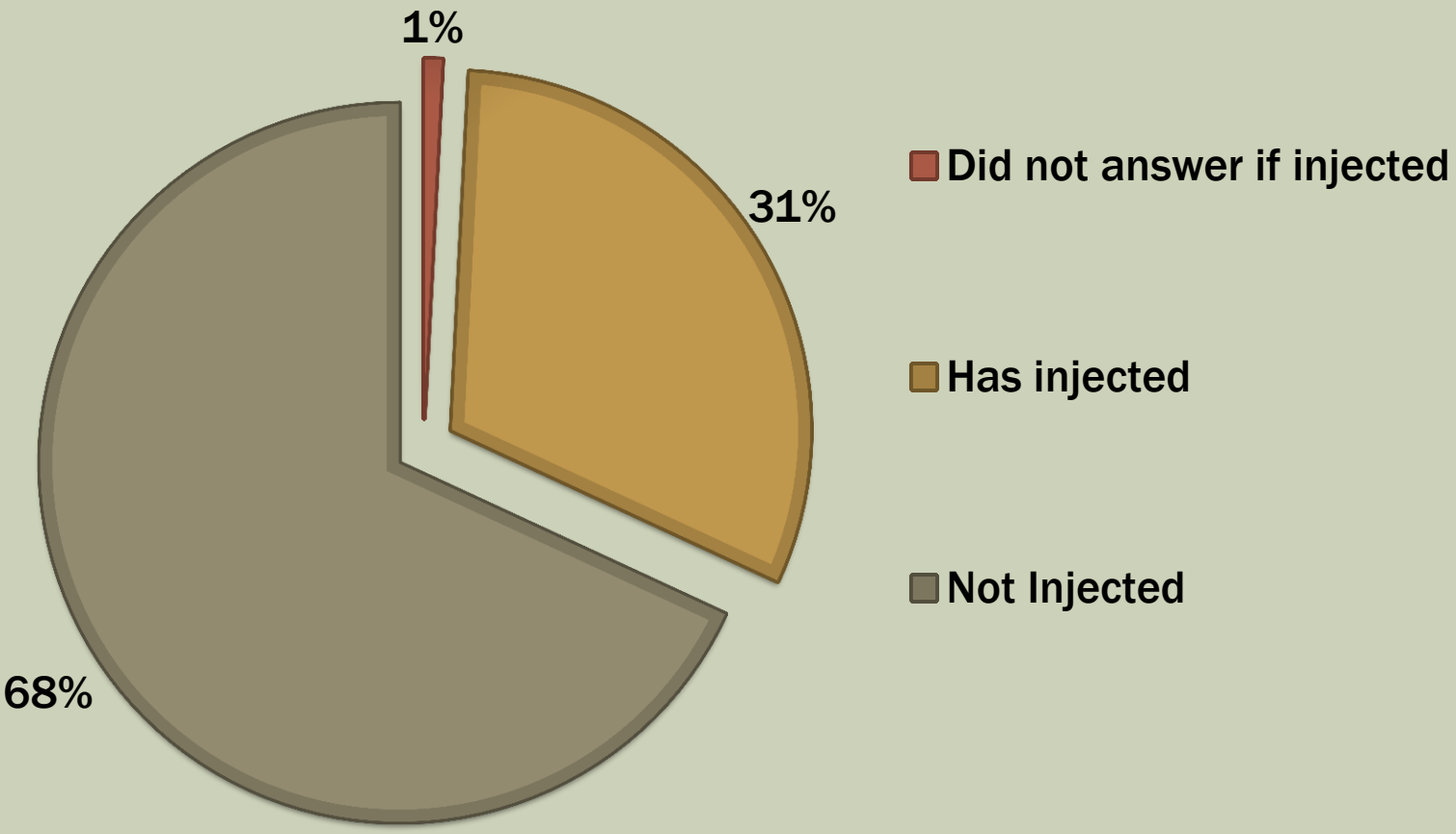
Opioid Type Abused Prior to Treatment



Sources Of Obtaining Prescription Opioids



Injection of Prescription Opioids



PATIENT FACTORS AND HEALTH RISKS

Patient Factors Driving Abuse

- Misperceptions about their safety
- Increasing environmental availability
- Varied motivations for their abuse

Health Risks

- Opioids
  - Addiction, overdose, heightened HIV/Hepatitis risk
- CNS Depressants
  - Addiction and dangerous withdrawal symptoms, overdose
- Stimulants
  - Addiction and other health consequences

POLICY CONSIDERATIONS

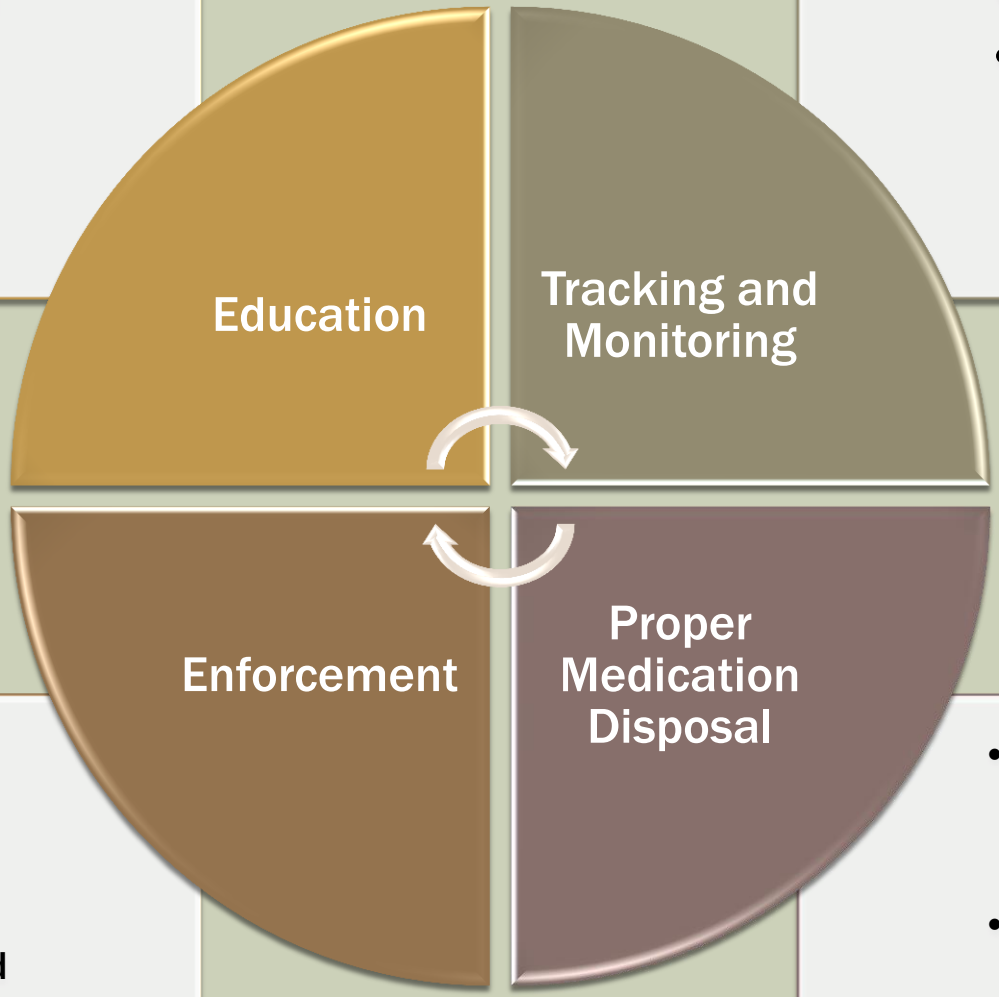
POLICY CONSIDERATIONS

Federal Government	• Education of health care providers and the public • Policies to prevent misuse and abuse while preserving access to meds
State Government	• Increase access to substance abuse treatment • Promote PDMPs and increase professional and criminal enforcement
Individuals	• Use prescription painkillers only as directed • Store meds in a secure place and dispose of them properly
Health Insurers	• Prescription claims review programs • Increase coverage for other treatments to reduce pain
Health Care Providers	• Follow guidelines for responsible prescribing and dispensing • Use PDMPs to identify patients improperly using prescription painkillers

WHITE HOUSE EXECUTIVE REPORT

- Parents and Youth
- Patients
- Providers

- PDMPs
- SBIRT



- Increase training, intelligence, information
- Aggressive professional and criminal investigations and prosecutions

- Secure, convenient, environmentally safe
- Compliant with Federal, State, and Local laws

OFFICE OF NATIONAL DRUG CONTROL POLICY (ONDCP) STRATEGY

5-year plan: Cut drug use among youth by 15 percent, drug-induced deaths and drug-related morbidity by 15 percent, and drugged driving by 10 percent

Seven core areas:

- Strengthen efforts to prevent drug use in communities;
- Seeking early intervention opportunities in health care;
- Integrating treatment for substance use disorders into health care, and supporting recovery;
- Breaking the cycle of drug use, crime, delinquency, and incarceration;
- Disrupting domestic drug trafficking and production;
- Strengthening international partnerships; AND
- Improving information systems to better analyze, assess, and locally address drug use and its consequences.

ONDCP PRESCRIPTION DRUG ABUSE PREVENTION PLAN GOALS

12 Months

- REMS for LA/ER Opioids
- Model Pain Clinic Regulation Law

18 Months

- IHS will increase the number of Collaborative Practice Agreements involving prescribing privileges and monitoring of pain therapy for pharmacists

24 Months

- National public education campaign
- Med disposal rules and reg's
- Prescriber training for schedules II/III meds
- FDA guidance on abuse deterrent formulations
- DOD, VA, and IHS provide info to PDMP
- 25% increase in state reimbursement for SBIRT
- 25% increase in HIDTA's

36 Months

- PDMP legislation in all 50 states
- 10% increase in funding for treatment

60 Months

- 15% decrease in unintentional overdose deaths related to opioids

CENTER FOR LAWFUL ACCESS AND ABUSE DETERRENCE (CLAAD)

- NATIONAL PRESCRIPTION DRUG ABUSE PREVENTION STRATEGY 2011-2012 Update
- Product of consultations with more than 40 experts from various sectors of society.
- Endorsed by 30 non-profit health and safety organizations and professional organizations including:
  - American Chronic Pain Association
  - Community Anti-Drug Coalitions of America
  - National Association of Drug Diversion Investigators
  - U.S. Pain Foundation

- http://www.claad.org/downloads/CLAAD_Strategy2011_v3.pdf

CENTER FOR LAWFUL ACCESS AND ABUSE DETERRENCE (CLAAD)

- Assessment
  - Initial and ongoing: routine for all patients
    - Past medical history
    - Risk factors (Hierarchal: low - high)
      - Biological
        - Age (<45yrs), gender, family hx of substance abuse, tobacco use
      - Psychiatric
        - Substance abuse, preadolescent sexual abuse (women), major psychiatric disorders (bipolar, anxiety, depressive, obsessive-compulsive)
      - Social
        - Poor family support, problematic subculture, prior legal problems
    - Treatment
      - Risk/Benefit

2011-2012 National Prescription Drug Abuse Prevention Strategy published by the Center for Lawful Access and Abuse Deterrence (CLAAD)

CENTER FOR LAWFUL ACCESS AND ABUSE DETERRENCE (CLAAD)

- Monitoring
  - Ongoing: routine for all patients
  - Varies with complexity of patient and therapy, as well as abuse risk potential
    - Prescription Monitoring Programs
      - Monitor patients access and prescribing practices
    - Urine Drug Tests
      - Identifying drugs in a patient's system
    - Treatments contracts/agreements
      - Mutual expectations and obligations of patient and healthcare community and clarifies boundaries for the patient
    - Considerations
      - High-risk patients
        - Weekly prescriptions and doctor visits
        - Avoid rapid onset formulations
      - Moderate-risk patients
        - Monthly prescriptions and doctor visits
      - Low-risk patients

2011-2012 National Prescription Drug Abuse Prevention Strategy published by the Center for Lawful Access and Abuse Deterrence (CLAAD)

TENNESSEE PRESCRIPTION SAFETY ACT OF 2012

TENNESSEE PRESCRIPTION SAFETY ACT

- Who MUST to be registered for the database?
  - All prescribers with DEA numbers who prescribe controlled substances and dispensers in practice providing direct care to patients in Tennessee for more than fifteen (15) calendar days per year shall be registered in the controlled substance database.
- When are you allowed to check the database?
  - A dispenser or pharmacist not authorized to dispense controlled substances conducting drug utilization or medication history reviews who is actively involved in the care of the patient
  - A dispenser having authority to dispense controlled substances to the extent the information relates specifically to a current or a bona fide prospective patient to whom that dispenser has dispensed, is dispensing, or considering dispensing any controlled substance

TENNESSEE PRESCRIPTION SAFETY ACT

- When **MUST** you check the database?
  - All prescribers or their extenders must check the database prior to prescribing any opioid or benzodiazepine to a human patient at the beginning of a new episode of treatment and at least annually thereafter as long as that drug remains part of their treatment
  - Before dispensing, a dispenser shall have the professional responsibility to check the database or have a health care practitioner extender check the database if the dispenser is aware or reasonably certain that a person is attempting to obtain a Schedule II-V controlled substance, identified by the committee as demonstrating a potential for abuse for fraudulent, illegal, or medically inappropriate purposes

TENNESSEE PRESCRIPTION SAFETY ACT

- How often do you have to report?
  - At least once every seven (7) days for all the controlled substances dispensed during the preceding seven (7) day period

- When do you **NOT** have to report to the CSMD?
  - Drugs administered directly to the patient
  - Drug samples
  - Drugs dispensed for a non-human by a veterinarian for a quantity of less than 48 hours supply
  - Registered narcotic treatment programs (21 CFR 1304.24)
  - Drugs dispensed by a licensed healthcare facility for a quantity of less than a 48 hour supply

Tennessee Controlled Substance Monitoring Program: Board of Pharmacy -Department of Health

227 French Landing, Suite 300 Nashville, Tennessee 37243-1149
Phone: (615) 253-1305 Email:CSMD.admin@tn.gov Fax(615) 253-8782

Patient RX History Report

John Brown

Date: 05-18-2012

Patients that match search criteria

Pt ID	Name	DOB	Address
422	Doe, John	01/07/1930	2407 Main St, Nashville TN 37214

Fill Date	Product, Str, Form	Qty	Days	Pt ID	Prescriber	Written	Rx #	N/R	Pharm	Pay
05/01/12	Fentanyl 50 mcg/hr, Patch	10	30	422	THC 6767	04/28/12	477625	N	BK4477852	01
05/01/12	Percocet 5/325 mg, Tablet	120	30	422	THC 6767	04/28/12	477624	N	BK4477852	01
04/01/12	Fentanyl 25 mcg/hr, Patch	10	30	422	THC 6767	04/01/12	378699	N	BK4477852	01
04/01/12	Lyrica 75 mg, Tablet	180	90	422	THC 6767	04/01/12	378697	N	BK4477852	01
04/01/12	Percocet 5/325 mg, Tablet	120	30	422	THC 6767	04/01/12	378698	N	BK4477852	01
03/02/12	Fentanyl 25 mcg/hr, Patch	10	30	422	THC 6767	03/01/12	111888	N	BK4477852	01
03/02/12	Percocet 5/325 mg, Tablet	120	30	422	THC 6767	03/01/12	111887	N	BK4477852	01
03/02/12	Xanax 0.25 mg, Tablet	45	15	422	THC 6767	03/01/12	111886	N	ML546578	01
02/01/12	Fentanyl 25 mcg/hr, Patch	10	30	422	THC 6767	02/01/12	999898	N	BK4477852	01

Fill Date	Product, Str, Form	Qty	Days	Pt ID	Prescriber	Written	Rx #	N/R	Pharm	Pay
03/02/12	Fentanyl 25 mcg/hr, Patch	10	30	422	THC 6767	03/01/12	111888	N	BK4477852	01
03/02/12	Percocet 5/325 mg, Tablet	120	30	422	THC 6767	03/01/12	111887	N	BK4477852	01
03/02/12	Xanax 0.25 mg, Tablet	45	15	422	THC 6767	03/01/12	111886	N	BK4477852	01
02/01/12	Fentanyl 25 mcg/hr, Patch	10	30	422	THC 6767	02/01/12	999898	N	BK4477852	01
02/01/12	Percocet 5/325 mg, Tablet	120	30	422	THC 6767	02/01/12	999897	N	BK4477852	01
01/01/12	Fentanyl 25 mcg/hr, Patch	10	30	422	THC 6767	12/28/12	565567	N	BK4477852	01
01/01/12	Percocet 5/325 mg, Tablet	120	30	422	THC 6767	12/28/12	565566	N	BK4477852	01
01/01/12	Lyrica 75 mg, Tablet	180	90	422	THC 6767	12/28/12	378697	N	MK454854	01

N/R: N=New R=Refill **Total Prescriptions: 17**

Pay:01=Private pay 02=Medicaid 03=Medicare 04=Commercial Ins. 05=Military Inst. And VA 06=Workers Comp 07=Indian Nations 99=Other

Prescribers for prescriptions listed

THC 6767 Robert Thompson 5656 Main St. Suite 7 Nashville, TN 37076

Pharmacies that dispensed prescriptions listed

BK4477852 Kapsule's Pharmacy 1604 Johnston St Nashville, TN 37076

MK454854 Main's Pharmacy 5660 Main St. Nashville, TN 37076

ML546578 Lemon Pharmacy 555 Main St. Nashville, TN 37076

**All persons and pharmacies are fictional and any similarity to actual persons or pharmacies is entirely coincidental*

QUESTIONS?

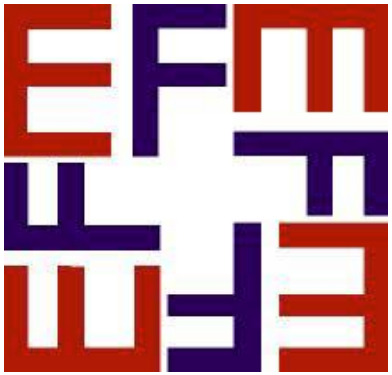
ECKMAN/FREEMAN & ASSOCIATES

Pain Management Appeals

For Tennessee Department of Labor and Workforce Development

Annette Moore, RN, CCM
Utilization Review Manager

About Eckman/Freeman



Company Profile

Founded in 1985

28 years experience in Disability Management

- **Case Management**
- **Utilization Review**
- **Vocational Services**
- **Social Security Disability Representation**
- **Life Care Planning**

Company Profile

- **Southeast Regional company with national capabilities through network partners**
- **Specialize in customized programs/solutions**
- **Certified professional staff**
- **Reputation for excellence in customer service**

Utilization Review Services

- Precertification/Concurrent Review
- Retrospective Review
- Peer Review/Causation Review
- Prescription Drug/Pharmacy Review
- Medical Bill Audit
- RN File Review with recommendations

24-48 hour TAT for standard UR

Pain Medication Appeals

Contract awarded to Eckman/Freeman January 1, 2013

UR appeals for Schedule II, III, IV

Pain Medication Appeals Process

- **Who can submit appeal?**

  Claimant, Physician, Attorney, Other claimant representative
- **Adjuster notified by TDOL if medications do not qualify for appeal**
- **Letter sent to adjuster requesting additional medical records**
- **Appeal sent to physician review**
- **Final appeal determination letter completed and sent to all parties**
- **2-5 day TAT after receipt of records**

Required Documentation

- **Previous UR denial**
- **All medical records submitted with initial UR**
- **Subsequent office visit notes and/or appeal letter from MD, claimant or representative, other pertinent information not submitted with initial review**

Most Commonly Denied Medications

- **Oxycontin**
- **Hydrocodone**
- **Morphine**
- **Lidoderm**
- **Xanax**
- **Soma**
- **Compound medications with multiple drugs**
- **Fentanyl**

Common Reasons for Denial

- Inadequate documentation
- No evidence of UDS or failed UDS
- Unproven long-term efficacy of medication
- Not recommended for claimant's diagnosis
- Prescribed dose does not coincide with recommended dosage
- No documentation of pain relief, functional status, appropriate use, side effects
- Lack of improvement in function and/or pain
- Risk of dependence and or risk of fatality

Thank you!

ECKMAN/FREEMAN
& ASSOCIATES

URAC
ACCREDITED
CASE MANAGEMENT